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# The Certified Chaplain in the Modern Hospital

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# THE CERTIFIED CHAPLAIN IN THE MODERN HOSPITAL*

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In examining such a subject as "The Certified Chaplain in the Modern Hospital" we need to remind ourselves that the hospital for the care of the acutely ill, as we know it today, is a relatively new institution upon the scene. While the hospital has its roots in several hundred years of history, actually going back to the time when the sick and suffering were taken into churches and cathedrals for healing, the modern hospital as such is a product of the last century. And until the last century only the poor went to hospitals.

Further, we need to remind ourselves, and only a brief reminder is necessary, of the long and significant history of the church and clergy in establishing hospitals, not only in America but upon the Continent of Europe and in other parts of the world, especially in the Orient. The five oldest hospitals in Chicago are church institutions, and this would be true of many communities. The founding of a hospital by an industrialist, such as Mr. Henry Ford, or by the community, city or state or Federal Government is very recent, aside from mental hospitals and tuberculosis sanitariums.

Therefore, in a sense, such a subject as, "The Certified Chaplain in a Modern Hospital," would appear to be somewhat strange. The layman or physician, looking at this subject might be inclined to ask, "Has not the chaplain, as a representative of religion, been in the hospital from its beginning?" The fact is that he has not; not as I will presently present him, even in church related hospitals. True, in those hospitals that were founded and maintained by the sacramental churches, the Lutherans, the Episcopalians, and the Roman Catholics, there have always been clergy, usually elderly men, whose primary task was to carry the Sacrament to the seriously ill and dying. But as a person with unique contributions to make in the care of the sick, as a member of the professional team, available at the request of the physician as he requests other consultants and specialists, the chaplain is very recent.

By certification we mean not so much that one passes an examination and receives a certificate, although this actually is done now by The Chaplains' Section of the American Protestant Hospital Association, as that a chaplain has received certain training and may be expected to work in a certain way. It is with this latter that I want to deal in this paper for this is the heart of our subject.

In 1924 The Rev. Anton T. Boisen, a Congregational minister, became the first full time chaplain in a state mental hospital and in time came to be recognized as the father of The Clinical Pastoral Training Movement. This movement is an effort to give the student for the ministry the kind of experience, under supervision, by way of preparation for his later ministry, that the internship

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affords the young doctor. Dr. Richard Cabot used to describe the internship "as that time when the young doctor makes his mistakes under some one else's responsibility." Actually it is an effort to give the doctor experience in carrying responsibility so that he is able to avoid mistakes that might otherwise be made, as well as to give him confidence in making decisions, carrying out and prescribing treatment.

Anton Boisen had been mentally ill. During his illness and following his recovery he became convinced that religion had much to contribute to the recovery of mentally disturbed persons. Upon his release from a Massachusetts state hospital he went to Boston where he met and studied with Dr. MacFie Campbell at the Boston Psychopathic Hospital and with Dr. Richard Cabot, who following World War I had resigned as Professor of Medicine at the Harvard Medical School to teach ethics at Harvard College.

You will remember something of Dr. Cabot's contributions in the field of medicine, the best known of which was the launching of Medical Social Work and the beginning of The Clinical Pathological Conference which led to the Cabot Case Records. Being a Boston blue-blood, a man of wealth, culture, and imagination, Cabot was quickly drawn to Anton Boisen and used both his influence and his checkbook to help Boisen launch his program. Earlier Dr. Cabot had urged for theological students what he called "a clinical year in work with those suffering from the infirmities of mankind." This plan was originally given in an address and later published in the Survey-Graphic in 1924. Boisen set out to meet this challenge although his own interests never seriously extended beyond the mental hospital.

To Dr. Boisen then, with Dr. Cabot's encouragement and advice, and through the courage of a hospital superintendent, Dr. William Bryan, goes the credit for first taking theological students into a mental hospital to gain experience. Those first students worked as attendants, studied case records, attended staff conferences and listened to lectures by the staff. The behaviour they observed and the ideas they heard expressed were a far cry from those they studied in the theological seminary and what they would use in their later work as pastors.

In 1930 The Council for the Clinical Training for Theological Students was incorporated with Richard Cabot as its first President and Dr. Flanders Dunbar as its director, and Dr. Phillip Guiles as field secretary.

In 1933 I went to The Massachusetts General Hospital as supervisor of theological students and later was appointed as chaplain there for The Boston Church Federation. Again, it was through the good offices, influence and financial support of Dr. Richard Cabot that such a project was possible in that conservative and complicated institution. It used to be said that it was almost impossible to get anything new started at The M. G. H. but once it was started it was almost impossible to get it stopped.

My own interest in The Pastoral Clinical Training Movement and ministry to the sick, like Dr. Boisen's, grew out of my own illness. As his mental illness took

him to the mentally ill so mine, a physical illness, took me to the physically ill in a general hospital.

Upon graduation from high school I developed tuberculosis of the left elbow which slowly progressed for three years. Finally, an orthopedic surgeon in Tulsa, Oklahoma, diagnosed the condition, opened the elbow and cleaned up the joint, but left it with motion as he did not know how to fuse an elbow. The disease promptly became active again; however, I was able to delay further treatment another year until I had finished college. When the Tulsa surgeon discovered that I planned to go east for graduate study he whimsically admitted, "Well, there are a few good orthopedic surgeons in New York City," and gave me a letter to the famed Dr. Russell Hibbs, founder of the New York Orthopedic Hospital. Two weeks after arriving in New York I reported to Dr. Hibbs, then in the later years of a great career, who, after examination ordered me into the hospital for immediate surgery, telling me bluntly, "That elbow is riddled with infection, but we may be able to save your arm."

At the New York Orthopedic I was operated upon by a young surgeon named Dr. Halford Hallock who had devised a method for fusing an elbow but had used the method only once and that was upon an early case while mine was well advanced. Later my x-rays were published when Dr. Hallock described his method, so that I have often said that while I may never be famous myself, I have at least been associated with a famous elbow.

During the months I was a patient at New York Orthopedic Hospital I received as good surgical care as could be obtained in the world, excellent nursing care, good dietary care, and total social service care; these four things are usually considered adequate for good medical care; and yet my religious faith ship-wrecked, adding mental anguish to the physical pain I had endured, so that if it had been possible I would have changed my profession upon recovery.

So it was that when I met Dr. Richard Cabot, early in 1933, to discuss the possibility of going to The Massachusetts General Hospital as a minister and he inquired, "Why are you interested in sick people?" I was able to give what to him was a satisfactory answer when I said, "I have been sick myself." His blunt response, which reveals the Cabot direct manner, or lack of manners, almost ruined our relationship before it got started when he said, "I'm glad you have." Whereupon I found it hard to pick up the conversation, for, without my knowing it then, my attitude was still marked by a deep feeling of hostility and resentment toward God for the severe suffering through which I had passed.

I mention all this to make clear my own attitude toward the subject under consideration and to show that my approach to the task of ministry to the sick is and always has been clinical rather than academic; it is rooted in personal suffering rather than in traditional theology. I became a chaplain, not because of religious conviction, but because in the hospital I felt I could find answers I had not found in the theological seminary and in the books.

During the years that have followed there has been a steady increase in the number of chaplains both in the mental hospitals and in the hospitals that care

for the acutely ill. Until now they number several hundred in church related hospitals, the Veterans Administration Hospitals, many tuberculosis sanitariums and infirmaries, non-secretarian private, state and federal institutions. Along with this development in the past ten to twelve years has come the employment of clinically trained instructors by the theological seminaries to teach what we call pastoral care and counseling. In these courses we not only deal with the subjects of ministry to the sick, dying and bereaved but study such problems as the emotional care of the child; premarital and marital counseling, work with alcoholics, problems of older people, anxiety problems in general, and that whole host of subjects that are meaningful as studied under the title of interpersonal relationships. You can well understand, however, that a person like myself continues to have as primary interest his concern for the sick.

## THE WORK OF THE CHAPLAIN

The problems of existence, destiny and death are philosophical, not scientific. How came we here? Why do we suffer? What is the meaning of life? What happens after death? These questions arise in the sickroom, in the clinic, and in the consultation room, because suffering crystalizes them into definite form. That they are not specifically expressed more frequently is because we do not permit them to come out.

There are several major emotional problems commonly faced in illness and in the hospital, and I repeat they are *emotional* problems: the philosophical problems of pain, anxiety, hostility, or resentment, guilt feelings and loneliness.

In THE ART OF MINISTERING TO THE SICK, published in 1936 (Cabot and Dicks) Dr. Cabot wrote, "The sickroom brings us two challenges: the fact of pain and the problem of pain. If we see no plan or purpose in the universe, if we think life a happenstance and death a darkness, we have no problem of pain, only the fact to be remedied or checked. The doctor faces the fact of pain. His job is to conquer it. He must come to some terms with the philosophical problem also, if he is to keep his poise in the face of the fact. Some never do. Some dodge it. They still are useful technicians. Nurses often dodge it; some become bitter or dull under the suffering they see. Most of them pass pain by as one of life's mysteries. They hold it at arm's length and let it hurt them as little as possible. Like the doctor they concentrate their attention on relieving it."

Dr. David T. Smith, past president of The American Tuberculosis Association says, "The tuberculosis patient does not really begin his recovery until he accepts his disease." (*Religion & Health*, May, 1952). I have requested Dr. Smith to describe just what he means by *acceptance of the disease* and how it is done and he has agreed to do so. Perhaps this same principle would apply to other diseases.

In my opinion Dr. Smith is referring to what I would call the problem of existence: What is the nature of the world in which we live? How came it here? How does it operate? What is my relationship to it?

This seems to me to be the problem of the person who commits or attempts to commit suicide. That is what the alcoholic is attempting to do: destroy himself.

Getting drunk for him is dying, and each time he realizes may be his last. And alcoholism is now considered the third health problem of the nation.

In both the fields of medicine and religion we handle these problems badly. At one hospital in Chicago where I served as Chaplain frequently girls were brought into the hospital from the rooming house district near by who had attempted to commit suicide. It was customary to work very hard with these patients. Pump out the stomach, give the patient oxygen, glucose, put her on precautionary nursing, build her up and get her well, and then send her out without anyone talking to her about why she tried to take her life, how she felt about it, and what her future plans involved. In other words, no one discussed her conception of her destiny, what her act meant, or what life meant to her, and what possibility it might have for her.

Hostility or resentment is found in most prople who attempt to commit suicide, and I have heard social workers claim that the same thing is true in almost all girls who become pregnant out of wedlock. Guilt feelings take many forms and are found pretty generally in most people when one digs into the inner recesses of their minds in a non-threatening way. Loneliness and a sense of isolation tie in so closely with the above emotional reactions that one hesitates to even identify this condition separately. However, there are times that it can be so clearly recognized, and plays such a significant role in the behaviour of a person, that it must be identified.

How much of a role these emotional conditions play in causing disease is anyone's guess. Some authorities believe they play a significant role; that they block the force that makes for health, that force which the doctor calls "nature" and which Dr. Cabot said should rightly be called "God." Certainly they play a vital part in the rapidity of the patient's recovery. And it can be said definitely that they are responsible for that fifty to seventy-five per cent of patients without organic disease who come to the doctor and who are sent out without a resolution of their problems.

There are five situations that the doctor faces in the hospital that I think the chaplain can be uniquely helpful in, and when I say "uniquely" I mean in dealing with the emotional-philosophical problem in these situations.

(1) With the patient facing serious major surgery. A surgical operation is a religious experience for the patient, whatever it may be for the surgeon. I have heard surgeons say that they disliked to operate upon a patient with a guilty conscience. A woman facing surgery the next morning told me of having told a lie ten years before. This was her effort to prepare for the operation the next day.

At Barnes Hospital in St. Louis where an unusual operation is performed upon women that have advanced cancer of the pelvic region, that involves not only a complete removal of the pelvic organs but a closing of both the rectum and the vagina, the chaplain routinely sees the patient two or three times before the operation. This is done at the request of the surgeon who first explains to the patient about the procedure and tells her that he has requested the chaplain to see her to

help her accept the operation and the post-operative condition that it involves. The surgeon who performs this daring operation has given his chaplain, George Bowles, adequate briefing in understanding the operation so that he can perform his supportive role.

(2) The patient who has suffered excessive pain needs to be seen by the chaplain. It is not that he can do much to relieve the pain. That is the job of the doctor and nurse. But he can help the patient understand and accept the pain when it is past. This is the problem I referred to above under the head of existence; it faces the question of how God functions in relation to the individual.

(3) Long convalescence such as the tuberculosis or the heart patient is facing calls for spiritual-emotional help. Closely linked with this situation is the problem faced by the handicapped person. These problems may be referred to as the problem of destiny. What can I do with my life? What does my illness mean? Why did this happen to me? I remember a twenty-four year old Jewish boy with almost every joint in his body stiffened by arthritis saying to me, "What does life hold for me? I can't even feed myself!"

The problem of destiny is faced outside the hospital as well as inside. In fact it may be considered one of the most basic and general philosophical problems of our people today, and undoubtedly, difficulty with it leads to the steady increase of anxiety that fills the doctors' offices and psychiatric institutions.

Has medicine an answer for this problem? Often even the doctor becomes discouraged with his reasons for being a doctor. I am not saying that religion has a satisfactory or acceptable answer for everyone, for the minister too gets discouraged, and a certain number kill themselves, but destiny and the meaning of life is a problem with which religion has traditionally dealt.

(4) There are many problems involved in the care and management of the dying that need careful study. There is the fact of dying and fact of death that need to be distinguished. Many patients worry about the fact of dying and seem to give little thought to the fact of death. "I was afraid I would not be able to die like a man," one patient said, "I didn't worry about the other."

Not all patients want to talk about death or dying, but some do. Not all want the ministrations of the church, but when offered in a non-threatening and non-punishing way most of them welcome the chaplain and come to depend upon his daily visits, drawing comfort, poise and courage from his faith and hope.

I remember a young woman facing death with sub-acute bacterial endocarditis whose doctor asked me to see her, but failed to tell her. When I introduced myself she said, "I don't like ministers." And yet a few weeks later it was not uncommon for the nurse to call me and say, "Lydia can't get to sleep. Will you come by and see her?" A few words and a brief prayer were all that were necessary to help her relax and fall asleep. Again, a matter of acceptance, whatever that word means.

(5) We have enough experience to indicate that whenever a patient upon admission to the hospital gives a history of grief, of death or separation, within a

year, from someone dear, a consultation by the chaplain is indicated. Grief, loneliness, separation, a sense of isolation, the breaking of a significant interpersonal relationship is serious in the lives of most persons. If the hostility is toward God, because the individual feels that God took, or killed, his loved one, then the chaplain may be quite helpful for the chaplain symbolizes God. Expressing hostility to him is like expressing it directly to God, and the relief is greater consequently.

In conclusion let me say, the certified chaplain, as trained and developed by the Clinical Pastoral Training Movement of the Boisen-Cabot tradition centers his attention upon the suffering person and his needs, not upon the doctrines and formulas of traditional religion. He seeks to be understanding and avoids judgemental and punishing attitudes. He is motivated by three scenes from the New Testament, (1) The Story of the Good Samaritan, in which the traveller does not ask if the sick and injured person is worthy or a "Christian," but only that he has needs; (2) The Story of the Prodigal Son, wherein one who seeks only to avoid starving is given a royal banquet; (3) The Story of the Thief on the Cross, who asks for nothing, not even for forgiveness but is accepted into paradise because of his attitudes.

These three stories the chaplain believes reveal the deep nature of the universe which at its heart is healing. "I dressed the wound, God healed it," said Ambroise Pare.